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Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma

R. Nick Gorton

Abstract: The United States is the only developed nation without universal health insurance (UHI). Among insured Americans, the majority are uninsured for transgender care because of policy exclusions. Advocacy for transgender health care primarily takes 2 forms: (a) using lawsuits to force public insurance to cover care based on parity and (b) encouraging private insurers to provide care based on equity and fairness. However, as the insurance crisis culminates, slow progress becomes dangerous: The increasing visibility of transgender care to politicians may cause its exclusion from UHI. Transgender care must be considered part of standard health care; thus, advocating for private insurance coverage of such care is crucial. This article details the sociopolitical forces that may exclude transgender care from UHI unless private insurance in the United States soon reflects parity and describes policy changes needed to facilitate this goal, as well as transgender parity within UHI.

Key words: sex reassignment; universal health insurance; gender identity; human rights campaign; transsexual

Transgender health care services occupy a contentious place in the U.S. health care system. Negative attitudes toward such care largely do not originate with health care providers treating transgender patients; rather, they result from discrimination and public misunderstanding of the medical necessity and effectiveness of such treatments. To date, the cost of services has been almost exclusively borne by individuals because of public animosity toward funding of transgender care. Recently, public and private health programs have begun to more openly cover what can be the single most important health care service for many transgender people: sex-reassignment treatment (SRT). These developments for the transgender community are occurring within the larger context of the dysfunctional U.S. health care financing system.

This article first presents the historical background of the health care financing system and details the current crisis in health care in the United States and then describes recent developments in the coverage of care for transgender people and shows where these changes will intersect with the larger health care financing dilemma. The transgender community and its supporters must understand the history of the U.S. system of health insurance in order to effectively alter the course of the impending crisis in coverage of transgender health care services. The slow progress in gaining coverage over the past few years may be halted and even reversed if action is not taken soon. This article concludes by describing some of the steps necessary to navigate a path to a future in which transgender health care is available to everyone who needs it in the United States.

Scope of the U.S. Health Care Financing Dilemma

According to the Centers for Medicare and Medicaid Services, the United States spent $7,110 per capita on health care in 2006 (Borger et al., 2006). Health care spending represented 15% of the U.S. gross domestic product (GDP) in 2003, the highest percentage of all

Address correspondence concerning this article to R. Nick Gorton, Lyon-Martin Health Services, 1748 Market Street, Suite 201, San Francisco, CA 94102. E-mail: nickgorton@gmail.com

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OECD[1] countries, which collectively spend an average of about 9% of their GDP on health care (Steinbrook, 2006). No other country matches U.S. expenditures either as a percentage of GDP or in actual dollars ("OECD Health Data," 2006). However, despite the high cost of health care, the United States trails other industrialized countries in performance measures. For example, among industrialized countries, the United States is tied for second-to-last place in infant mortality (*The World Health Report 2005*). The poor performance of the U.S. system is not surprising considering that a quarter of U.S. adults under 65 are uninsured for all or part of each year and more than one third are either uninsured or underinsured (Schoen, Doty, Collins, & Holmgren, 2005). Furthermore, this number has risen steadily over the preceding years and is expected to continue increasing (Collins, Davis, Doty, Kriss, & Holmgren, 2006). During this same time frame, the health care system has become increasingly ill equipped to provide for the high levels of uncompensated care that the growing, increasingly uninsured U.S. population requires. Currently, the only health care that is mandated (and often the only care accessible to the uninsured) is based in hospital emergency departments (EDs), which are the de facto safety net for U.S. health care. This situation has resulted in what the Institute of Medicine (2006) has referred to as a "national crisis in emergency care" (p. 15).

The mounting pressure on the failing method of financing health care in the United States is culminating in a crisis that will force either Congress or multiple state legislatures to act in the next several years. Currently, half of all personal bankruptcies in the United States stem from health care debt and almost 60% of those filing for bankruptcy were insured when they initially fell ill but subsequently lost their coverage, often due to loss of employment or inability to afford premiums after illness set in (Himmelstein, Warren, Thorne, & Woolhandler, 2005). Recent polls have shown that the majority of Americans favor government-guaranteed universal access to health insurance (Harris Interactive, 2007; Quinnipiac University Polling Institute, 2007; Toner & Elder, 2007). Surveys of U.S. physicians suggest that the majority also favor a single-payer system (McCormick, Himmelstein, Woolhandler, & Bor, 2004). With such pressures building, it is increasingly obvious that the most economically viable solution is a system of national universal health insurance (UHI) similar to Medicare (the federal health insurance program for disabled people and those ages 65 and older) that covers all Americans regardless of age. Understanding the social and political factors that may force the government's hand in establishing a UHI program is necessary for understanding how this move may affect future health care options for transgender individuals under such a program. Regardless of the solution to the U.S. health insurance dilemma, contentious services and disenfranchised populations will be at the center of intense debate when questions arise over precisely who and what will be covered under expanded health insurance or UHI.

Evolution of the Current Health Care Financing Crisis

The insurance industry, the pharmaceutical industry, and some physician organizations (such as the American Medical Association [AMA]) have opposed proposals for UHI for decades (McCanne, 2004). Since then president Roosevelt jettisoned UHI under pressure from the then even more powerful AMA to ensure passage of the Social Security Act in 1935, opposition has prevented meaningful reforms. The single important exception was the passage of Title XIX of the Social Security Act in 1965, which established Medicare and Medicaid despite opposition from the AMA and the health care industry (Blumenthal, 2006).

As the overall cost of medical care increased in the 1970s and 1980s, payers demanded cost controls. This situation spawned the managed-care movement, which succeeded temporarily in decreasing the cost of health insurance, purportedly by improving efficiency. Unfortunately, this improved efficiency was largely due to reducing *cost shifting,*[2] a strategy that had been crucial to supporting the unstable system of health care financing in the United States (Dobson, DaVanzo, & Sen, 2006). Hospitals and many doctors who had provided care to indigent patients by shifting the costs of their care to insured patients were no longer able to do so sufficiently to meet the increasing need. Managed care's claims of lower cost through improved efficiency were largely the result of pressuring providers to charge fees closer to the actual cost of providing care to insured patients and of higher rates of denial of payment for services deemed necessary by providers. This inability to shift the cost of uncompensated care to insured patients

1 OECD (Organisation for Economic Co-operation and Development) is an international organization comprising 30 developed and largely Western and high-income countries sharing a commitment to democratic government and the market economy.

2 Cost shifting refers to the practice of charging insured patients a higher price for a given health care service to cover the cost of delivering that service to all of the patients, both insured and uninsured, seen by a given provider.

resulted in doctors and hospitals being less willing to provide indigent care.

Unfortunately, as more and more providers removed themselves from the pool that provided uncompensated care, remaining providers faced increasing pressure to care for a larger percentage of the expanding pool of uninsured patients. This situation resulted in the first *emergency care crisis* in the United States, in the mid-1980s. Hospitals that were unwilling to provide uncompensated care simply refused to accept ambulances carrying uninsured patients or would immediately transfer the patients to other facilities. Reports in the medical literature and the popular media described numerous types of what came to be termed *patient dumping*: ambulances circling multiple hospitals in search of a facility willing to accept uninsured patients, EDs at private hospitals sending patients with overwhelming bacterial meningitis by private car to a public hospital without administering even a single dose of antibiotic, and pregnant women who were transferred while in active labor giving birth in ambulances (Korcok, 1985). These stories eventually created such a furor that Congress was forced to act.

The resulting Emergency Medical Treatment and Active Labor Act (EMTALA; 1986) required all EDs to provide a medical screening exam and emergency medical treatment to any person with an emergency medical condition and to all women in active labor. EMTALA, however, did nothing to reform health care financing and ultimately simply delayed the emergency care crisis to a later time when the pressures had multiplied. Over the ensuing years, some hospitals sought to evade compliance with EMTALA through numerous creative but largely unsuccessful means. The unfortunate result was that many hospitals and EDs, often those that served more impoverished areas with a higher proportion of uninsured patients, were forced to close their doors because of financial difficulties. From 1993 to 2003, 425 hospital EDs closed their doors; the number of ED visits rose by 26% during the same period (Institute of Medicine, 2006).

However, whereas hospitals have been largely unsuccessful in avoiding the burden of providing uncompensated care, individual physicians, particularly specialty physicians, have had more success. The result has been America's second emergency care crisis, often termed the *on call crisis*. EDs and emergency-room physicians must provide emergency care, but specialty physicians (many of whom have the skills needed to care for emergency medical conditions) are responsible for uninsured patients only when they are on call at a hospital. Over the past decade—and especially since 2003, when the Centers for Medicare and Medicaid Services published new rules for interpretation of EMTALA (1986)—many specialty physicians, including orthopedic surgeons, hand surgeons, neurosurgeons, and even obstetricians have effectively removed themselves from large parts of EMTALA liability primarily by eliminating or severely limiting their on-call hours at hospitals where they practice (McConnell et al., 2007). EMTALA allows hospitals unable to care for a patient to transfer that patient to a facility with greater resources, more capacity, or both. For example, if a small community hospital does not have a neurosurgeon on staff, EMTALA allows that hospital to transfer neurosurgical emergency patients to hospitals with the necessary services. Specialty physicians quickly learned that the best way to avoid the EMTALA mandate to provide uncompensated care was simply to avoid being on call for that care in the first place (Institute of Medicine, 2006).

In addition to specialists, hospitals and EDs overburdened with patients waiting for hours and even days for care are also allowed a reprieve under EMTALA (1986): EDs with full beds are allowed to divert ambulances bringing in certain types of emergency patients. Ambulance diversion is now reaching the point at which the crisis from the 1980s is being repeated, only with a telling difference: Whereas in the 1980s only poor and uninsured patients were forced to circle EDs in ambulances and were deprived of timely emergency treatment, now even insured and affluent patients are subject to ambulance diversion. Furthermore, if the closest hospital that provides a specialty service is hours away, even insured patients may find that the emergency care they need is unavailable. These forces have cumulatively produced an unsustainable situation that will force a legislative solution to the problem—a solution that may manifest in some form of a national UHI program or multiple state UHI plans.

The Politics of UHI: Lessons From Medicaid and the Americans With Disabilities Act

If UHI becomes a reality, it will be the result of a pitched political battle. Conservative lawmakers and pundits, likely echoing the positions of two of the largest lobbying groups in Congress (the health insurance and pharmaceutical industries), will make every attempt to feed Americans' unrealistic fear of socialized medicine as they did in 1993. However, the arguments that held sway in 1993, such as those portrayed in the "Harry and Louise" television commercials[3] produced by the Coalition for

3 These commercials depicted a middle-class American couple despairing at the bureaucracy of a potential single-payer health insurance system with statements such as, "It says here that under the president's plan we won't be able to choose our doctor" (Roberts, 1994).

Health Insurance Choices (a front group for the Health Insurance Industry Association), lack sufficient credibility today to feed public fears of a UHI system (Goldsteen, 2001). For example, many insured Americans already experience lack of access to a preferred physician or treatment through denials by managed health care. Thus, the arguments that a UHI system would limit people's physician and treatment choices are less credible.

In the United States, the disparity broadens daily between per capita spending on health care and people's access to care and ultimate health outcomes when compared with those of other developed nations. This disparity demonstrates the fallacy of arguments that providing health care to all will be prohibitively expensive. In addition, people are becoming increasingly aware that the cost of prescription medicines in the United States is disproportionately high compared with that in other nations. Furthermore, whereas in the early 1990s being uninsured was largely a problem confined to the poor, it now increasingly crosses class lines, with 18% of middle-income adults and 7% of high-income adults in the United States reporting having no health insurance for all or part of the year in 2005 (Collins et al., 2006). As Michael Moore (2007) detailed in his recent film *Sicko,* uncertainty surrounding health care access is now a solidly middle-class American phenomenon. These shared experiences of the precariousness and limitations of health care in the U.S. system make older arguments less plausible and a less viable tool for opponents of UHI.

Therefore, the opposition to a UHI program will depend more heavily on alternative arguments to limit or defeat such legislation. A natural choice for this strategy is to describe the plan as being too liberal in that it would cover individuals who will be portrayed as undeserving and provide services that will be depicted as unnecessary. Obvious targets for such increased scrutiny will be groups such as undocumented immigrants and the unemployed, as well as services that are contentious—including abortion services, (nonpunitive) drug treatment programs, and transgender-related care. The goal of opponents will be to defeat any form of UHI; if a UHI plan is enacted, a likely result will be legislative exclusions of politically unpopular benefits and populations.

For the transgender community, vulnerability to these exclusions partially results from the increasing visibility that is a necessary part of any civil rights movement. For example, when Title XIX (1965) of the Social Security Act was enacted 4 decades ago, it included no explicit exclusions of transgender care. When the bill was debated, transgender people were almost unknown outside of a small circle. The idea that people would seek SRT within Medicaid in all likelihood simply did not occur to those drafting the bill. Specifically, Title XIX states that Medicaid agencies "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition" (§ 440.230(c)). As a result of this lack of specific exclusions and favorable language, transgender people have in a small but growing number of instances successfully challenged denials of SRT under Medicaid (Minter, 2003).

The Americans With Disabilities Act (ADA), which passed more than 2 decades later in 1990, stands in stark contrast to Title XIX (1965). In an attempt to prevent Congress from approving the ADA, former senator Jesse Helms raised the specter that the law would provide disability protections to numerous politically unpopular groups—including, as he stated, "people who are HIV positive, most of whom are drug addicts or homosexuals or bisexuals" (Hong, 2002, p. 108), as well as pedophiles, kleptomaniacs, transvestites, and so forth. Although Helms's manifest public targets were these so-called deviant groups, they were largely just a politically convenient weapon with which he could target the larger issue of disability rights legislation. However, as a direct result of Helms's efforts, an explicit exclusion of "transvestism, transsexualism, [and]…gender identity disorders not resulting from physical impairments" (Americans With Disabilities Act, § 12211(b1)) was added to the definition of disability when the ADA was eventually enacted (Colker, 2004). Therefore, although obtaining transgender services through Medicaid is difficult but possible depending on the court, obtaining federal protections through the ADA involves convincing courts not only that gender identity disorder[4] is a legitimate illness needing treatment but also that the exclusion within the law itself is unconstitutional—a much more formidable challenge. To date, no court has struck down the ADA's exclusion of transgender people (Levi & Klein, 2006).

This contrast between Title XIX (1965) and the ADA (1990) emphasizes the importance of preventing the introduction of exclusionary language in any UHI bill. Unfortunately, the transgender community will not be able to pass under legislators' radar as it did in1965 with the institution of Medicaid. Transgender people will be forced both to defend themselves as deserving of care and

4 Gender identity disorder is the diagnosis in the *Diagnostic and Statistical Manual of Mental Illness* (American Psychiatric Association, 1994) under which transgender people have traditionally been treated and according to which most legal challenges to discrimination in health care access have been argued.

to demonstrate the validity and medical necessity of SRT (M. Keisling, personal communication, April 1, 2007). In order to effectively combat arguments such as those that resulted in the exclusion of transgender people from the ADA, it is necessary to predict and be prepared to address such claims from opponents.

Inclusion of Sex-Reassignment Treatments in UHI: A Plausible Pipe Dream

The effectiveness of arguments against inclusion of transgender people in a UHI program is tied to their appeal to ignorance and prejudice about who merits health care and what defines *necessary services*. Individuals who deviate from cultural norms are typically perceived as less deserving of quality care. Specifically, services that allow them to maintain such so-called deviant practices are seen as neither necessary nor desirable for society—regardless of any evidence that such care is beneficial to the individual or society. For example, needle exchange programs (NEPs) repeatedly have been shown to decrease the transmission of blood-borne infections such as HIV and to lessen the overall use of intravenous drugs of abuse (Wodak & Cooney, 2006). However, NEPs are politically unpopular because they are perceived as facilitating deviant activities. Because of this public rejection of NEPs, the United States is the only country in the world with a ban on federal funding of NEPs, leaving these effective public health programs largely unfinanced (Vlahov et al., 2001). As this example makes clear, scientific evidence of safety and efficacy are often trumped by political unpopularity.

Because the questions of deviancy and moral value will be raised, the clinically based arguments that SRTs are safe and effective, decrease suicidality, and improve quality of life for transgender people may be necessary but insufficient to refute the political forces pressing to exclude SRT from a UHI program. When evaluating the existing medical knowledge, the appropriateness and utility of such treatments is evident. However, in order to effectively challenge claims based on the idea of deviance, transgender advocates and their allies in medicine must demonstrate that such treatments are a part of typical and necessary medical care. One of the more intuitive ways to demonstrate this point is to show that this care is already a covered benefit in existing health insurance programs (both public and private).

History of Transgender Inclusion in Health Insurance Plans

Until the last decade, coverage of SRT in public and private health plans was almost nonexistent in the United States. Although inroads were certainly made in numerous areas, one critical turning point regarding coverage of SRT in employer-sponsored health plans occurred in February 2001 when San Francisco adopted policies that included SRT in the coverage for city and county employees. These policies provided direct benefits to only a dozen transgender people who were among the 27,000 city employees of San Francisco. However, this action has had far-reaching effects. In the 6 years since the institution of these benefits, the San Francisco experience has provided actuarial data demonstrating that fears about the high costs of SRT were completely unfounded—by more than an order of magnitude.[5] Moreover, the claim that transgender people would disproportionately seek employment in the San Francisco system was also disproved. Finally, even more absurd claims—for example, that with benefits available, more people would decide to reassign their sex through surgery and hormones—were also debunked (J. Green, personal communication, October 13, 2006). Thus, in addition to providing direct benefits to a handful of people, San Francisco's experience provided concrete data to address future opposition to including SRT in other health plans. By July 2004, San Francisco had removed transgender exclusions from each of its health insurance policies (Health Net, Blue Cross/Blue Shield, and Kaiser) for all city and county employees, retirees, and their dependents (Wilkinson, 2006).

Since the 2001 public victory in San Francisco, more than 70 private and public employers—such as the University of California, Microsoft, DaimlerChrysler, Cigna, Guidant, Coca-Cola, Lucent, and Bank of America—have added coverage of SRT to their employee benefits.[6] In a recent assessment of insurance options for coverage of SRT prepared for companies seeking such coverage, a private employee benefits company in California found that of 10 insurance providers they surveyed, only one (Universal Care), provided no plan options or riders for companies seeking to provide transgender-inclusive health insurance to their employees (Financial Independence Company Insurance Services, 2006). Only 5 years previously, San Francisco had to self-insure for SRT because of the lack of available insurance plans that provided this type

5 The city and county of San Francisco initially had to self-insure for sex-reassignment treatment benefits for employees and increased insurance premiums to cover the expected costs. Between 2001 and 2004, they collected an additional $5.6 million of which only $186,000 was paid on 11 claims. The actual additional cost during that period was less than $1 per employee per year (Wilson & Green, 2006).

6 For more information on specific employers who provide benefits, see Human Rights Campaign's searchable database at http://www.hrc.org/worklife/pqsearch.

of service (J. Green, personal communication, October 13, 2006). In addition, the American Medical Association this year adopted policy that opposes health insurance discrimination against transgender people (American Medical Association, 2007).

In addition to employer-sponsored plans, advocates have made some halting progress in increasing the coverage of SRT through Medicare.[7] California in particular now routinely provides for psychiatric and medical treatments for transgender people through Medi-Cal (the California Medicaid program) and has approved a few patients for sex-reassignment surgical procedures. Indeed, as a provider treating transgender patients in California, my experience has been that the biggest limitation for Medi-Cal recipients who want sex-reassignment surgery is finding qualified surgeons who accept Medi-Cal as payment. But despite these advances, Medicaid coverage for SRT is under attack. Two states, Minnesota and Washington, that have in the past provided such care have reduced coverage in the past few years under political pressure (Lerner, 2005; Thomas, 2006).[8] Thus, although Medicaid coverage of SRT is a beneficial part of the argument for including transition-related care in UHI, the argument's efficacy may be limited because such coverage is not typically available in most states—and in those few states that comply with Title XIX (1965) and do not discriminate against individuals simply because of their diagnosis, SRT coverage remains under constant political threat (Minter, 2003). Furthermore, only a small minority of the U.S. population currently has public or private insurance that covers SRT. The remaining public and employer-sponsored plans do not provide adequate coverage for the health care needs of transgender people.

Objections to Advocacy Work Regarding Transgender Inclusion in Private Health Plans

Some advocates have suggested that seeking transgender-inclusive coverage through employers or private insurance companies like those described above undermine efforts for UHI. Vivian Namasté (2005) has argued that efforts to gain coverage for SRT in employer-sponsored health insurance policies are inherently misguided in that they legitimize the already oppressive system in the United States that links access to health care with employment status, wealth, or both. She cites activists' work in San Francisco to provide SRT benefits to public employees as a specific example of what she believes is misguided advocacy. Although Namasté's concerns about the U.S. system, which excludes millions from access to health care, is apt, I would argue that advocacy for SRT benefits in the current system is essential to the fight for a trans-inclusive UHI program. Ultimately, this advocacy work strives not only to allow services for individuals in the short term but also to demonstrate that such care is reasonable, economical, and medically necessary—as it forges a path for future transgender health care advocates to follow. Each time SRT is recognized as a legitimate part of any private or public health insurance plan (which generally cover only treatments defined as medically necessary), this recognition solidifies the idea of trans health care as both a normal part of health care and as a medically necessary service. Such gains are needed to bolster perceived legitimacy for SRT so that advocates can argue convincingly that SRT is appropriate in any UHI system.

Moreover, efforts to gain health care for transgender people necessarily involve advocacy for the uninsured because even transgender people with private insurance in the United States are nearly universally uninsured with regard to what is often the single most important health care concern they have (C. Daley, personal communication, February 18, 2006). Even educated, affluent, and employed transgender people are generally uninsured or at best underinsured with regard to SRT. Certainly, many transgender people inhabit the intersection of multiple forms of discrimination; however, in the United States, nearly all transgender people are vulnerable to significant discrimination with regard to health care access. Therefore, in addition to serving to solidify arguments that SRT is medically necessary and appropriate, seeking private insurance coverage provides direct benefits to a group nearly universally disenfranchised regarding health care. Fighting simultaneously for private insurance programs, Medicaid programs, and employee health plans to cover transgender health care is meaningful not only to increase health care access now but also as preparation for the fight to have SRT included in UHI.

The Intersection of Transgender Health Care and the Health Care Financing Crisis in the United States

From my position as both an emergency medicine physician in the United States and a provider, advocate, and member of the transgender community, the crises

7 For a detailed discussion of advocacy for Medicaid coverage of sex-reassignment treatments, see Ben-Asher (2006).

8 In addition to its state Medicaid program, Minnesota has several employer-sponsored insurance plans that have covered sex-reassignment treatment for many years. This fact has been less publicized for Minnesota than for California, likely due to the fact that the only university-affiliated gender program in the United States that has survived since the 1970s is the Program in Human Sexuality at the University of Minnesota Medical School (R. Ehrbar, personal communication, May 1, 2007).

evolving in both of these arenas seems like an unavoidable collision I am witnessing in slow motion. The urgency of the health care crisis facing the transgender community mounts daily with the increased visibility and, thus, increased vulnerability of the transgender community to political scapegoating. In addition, the destabilizing positive feedback processes in the U.S. system of financing health care are also reaching a predictable and unsustainable peak. Although nothing is certain, the current course that the United States is traveling—which, if unaltered, will cause the collapse of the emergency care safety net—coupled with the tendency of conservative politicians and pundits to target marginalized groups, makes efforts to exclude SRT from any UHI almost inevitable. With the recent election of a Democrat-controlled Congress, and especially if Democrats win control of the White House in 2008, UHI may be a reality in the United States within a few years. Even without a federal UHI program, this same political battle will be played out numerous times in individual states. If a federal solution is created, a likely candidate for such a program is Rep. John Conyers's Expanded and Improved Medicare for All Act of 2003 (H.R. 676).

As the Expanded and Improved Medicare for All Act of 2003 is currently written, SRT would not necessarily be excluded from Medicare. Section 102 of the bill states, "The health insurance benefits under this Act cover all medically necessary services." Section 204 states, "The Program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions." Because gender identity disorder has been recognized as a psychiatric diagnosis and mounting medical evidence has demonstrated the efficacy and safety of SRT, unless specific exclusions are added to the bill, such wording will allow for a solid argument for inclusion of SRT in Medicare, much the same way that Medicaid coverage is now pursued.

Making the Implausible Possible: Increasing Transgender Inclusion in Employer-Sponsored Health Plans

As demonstrated in the preceding sections, unless progress is made toward normalizing SRT within public and private systems, the collision of UHI and transgender care seems almost inevitable. Such normalization is most readily and rapidly attainable through increasing the number of existing employer-sponsored health insurance plans that cover SRT. Although legal cases involving exclusion of SRT under Medicaid are also essential to the argument, they can take many years to resolve because of the political unpopularity of SRT benefits. Legal cases of this sort that are not currently in progress are unlikely to be resolved within a few years, making them less useful as examples if the debate for UHI becomes a reality in 2008. However, challenges targeting private employers' health plans may give more timely results.

Numerous advocates are pressuring employers and insurance companies to include SRT benefits. As more actuarial data emerge demonstrating the affordability and sustainability of such policies, advocacy becomes easier (Wilson & Green, 2006). However, the overall slow progress of such advocacy may not provide enough of a precedent soon enough to prevent exclusionary language from limiting transgender benefits in a UHI program. Therefore, instead of making incremental changes that have to be reinvented each time in challenges to individual employers, a more systematic approach is needed—one that will pressure employers as a group to offer SRT benefits in their insurance policies.

The most obvious choice for such a systematic approach is with the Human Rights Campaign (HRC) Foundation's corporate equality index (CEI). The CEI is an existing tool that has already made an impact on private employer policies regarding equity for politically unpopular groups. Since its initial publication in 2002, the CEI, which "examines and evaluates corporate policies affecting Gay, Lesbian, Bisexual, and Transgender throughout the [United States]," (Human Rights Campaign [HRC] Foundation, 2006, p. 1) has become invaluable in the fight to change corporate standards regarding lesbian, gay, bisexual, and transgender (LGBT) employees. The HRC collects data for the CEI entirely from surveys completed voluntarily by employers, a method that poses significant limitations for the CEI because it is, therefore, not based on an objective assessment of employer policies. However, although it does not necessarily providing the highest-quality data for research purposes, the CEI does provide a publicly available measure by which potential employees and consumers can assess corporations (Ayres & Brown, 2006). Corporations that are known as being diverse and inclusive and as having exemplary affirmative action policies have shown improved financial and organizational performance, whereas public awareness of violations of equal employment opportunity laws has been associated with decreased profitability (Reid & Friedman, 2005). Thus, even though the CEI provides what may be an imperfect measure of corporations' treatment of LGBT employees and customers, it does provide a public score by which corporations can be judged. The HRC is, therefore, correct in its own assessment of the CEI when it states that U.S. businesses "know that a good CEI score means a healthier work environment, greater productivity and the ability to

recruit top talent. They also know that a bad score is bad for the bottom line" (HRC Foundation, 2006, p. 1).

Using the CEI as an Impetus for Change

Despite having such a valuable tool to effect policy change, the HRC has so far declined to use the CEI to advocate for true equality for all LGBT employees. Despite inclusion for the first time in 2006 of a measure of health care benefits for transgender employees (described by the HRC as transgender wellness benefits), employers that offer insurance policies completely excluding all forms of SRT not only can still be listed as offering transgender wellness benefits but also can score 100% on the CEI. Unfortunately for the transgender community, the HRC's current definition of perfect corporate equality does not include extending real equality to transgender employees.

The HRC chose to include this new criterion of "transgender wellness benefits" (criterion 2c; HRC Foundation, 2006, p. 11) without providing a meaningful measure of companies' provision of equity in health care for transgender employees. Criterion 2c provides 5 points out of 100 possible on the CEI for corporations who provide any one of the following without explicitly excluding benefits related to SRT: mental health counseling, pharmacy benefits covering hormonal treatments, physician visits and lab procedures to monitor treatment, short-term disability leave for surgery, or "medically necessary surgical procedures (i.e., hysterectomy)" (HRC Foundation, p. 55).

The aforementioned description of criterion 2c makes obvious that this survey question is not a real measure of equality for transgender employees, but a barely noticeable impediment for corporations seeking a higher score on the CEI. Simply allowing employees leave from work for surgery that the employee must pay for in full earns corporations the full 5 points. Moreover, the wording of the survey question regarding surgical procedures is somewhat troubling: The selection of hysterectomy as the example of what might be medically necessary does not truly address transgender benefits because hysterectomy is neither necessary nor desired by the majority of transgender people (no transgender women and only a portion of transgender men need to undergo hysterectomy as part of transition). Indeed, in my experience as a provider, significantly more transgender men require and wish to pursue chest reconstruction than hysterectomy—so even among transgender men, hysterectomy is not a very commonly performed surgery. However, by using the wording *medically necessary surgical procedures (i.e., hysterectomy),* the HRC again subtly skirts the edge of assessing real benefits in that it references the single surgical procedure that is relatively common in both transgender and *cisgender* (nontransgender) people as exemplifying the medically necessary surgical procedures that are a part of SRT.

Moreover, other wording in the HRC employer survey is similarly hesitant to set clear standards for transgender benefits, using verbiage that is not otherwise used regarding benefits, such as same-sex partner benefits, for questions about SRT insurance benefits. For example: "For health care benefits available to your general work force, is there at least one company-sponsored plan that does not specifically exclude benefit coverage for transgender, transsexual or gender dysphoria-related treatments?" (HRC Foundation, 2006, p. 55). Obviously, the lack of specific exclusions is not equivalent to inclusion. However, despite the HRC's use of the word *inclusion* when assessing a number of other policies and benefits in the CEI survey, the word *nonexclusion* is used only once in the survey—with regard to transgender wellness benefits.

Not surprisingly, 68% of employers surveyed fulfilled the minimal requirements of criterion 2c—a much smaller percentage (15%) of employers who completed the CEI survey offer real parity for transgender employees in that they provide full SRT-inclusive insurance benefits. Indeed, less than half of those employers who scored a perfect 100% on the CEI offer real parity for transgender employees (HRC Foundation, 2006). This situation is unfortunate given the current volatile political environment in which SRT might be legislatively excluded from a UHI plan. The HRC could easily assess real equity with the CEI and, with the data already collected and used to generate the current CEI, the HRC could differentiate between companies who report providing full SRT-inclusive benefits and those who offer only minimal benefits. By making such distinctions regarding transgender equity, the HRC would set the bar for equality at full parity for transgender employees. If their coveted 100% CEI scores were in jeopardy, and with the increasing availability and affordability of transgender-inclusive insurance policies, corporations consequently would be pressured to adopt full parity for transgender employees. This action would use the CEI as the powerful tool it has become to create rapid change in the corporate environment regarding LGBT policies and benefits.

Actuarial data from the San Francisco experience (Wilson & Green, 2006) showed that SRT is not prohibitively expensive and now, as even more employers offer coverage and insurers gain experience with offering SRT, additional data demonstrating affordability are being generated. Numerous insurers now offer transgender-inclusive policies or riders. On the 2006 CEI survey,

67 corporations stated that they offer full SRT-inclusive coverage—evidencing the fact that SRT-inclusive insurance is available if employers desire it. Previously, before such insurance was more widely available, there was some validity to the argument that a measure of true equity would have prohibited most employers from achieving 100% compliance even if they wished to be inclusive. However, with the insurance options currently available to employers, that is no longer a reasonable excuse for any of the corporations assessed in the CEI.

Were the HRC to choose to assess real equality and thus expect full parity in health insurance for transgender employees, the number of corporations who offer such care would in all likelihood increase substantially in a relatively short period of time. With the urgency of normalizing SRT as appropriate, usual, and medically necessary care before the coming political conflict over UHI, such action is not only desirable but also imperative if the HRC wishes to serve the needs of the transgender portion of the LGBT community.

Conclusion

Recent polls have suggested that an increasing majority of people in the United States favor a government program guaranteeing universal access to health insurance. In addition to having the support of the majority of Americans, UHI has become a financial necessity to save the imploding emergency medical care system that has been the de facto safety net for millions of uninsured people for more than 2 decades. However, legislation that provides guaranteed health care to every American will come only after battling strong conservative opposition. Such opposition will inevitably use controversial benefits and recipients such as SRT and transgender people in order to rally public sentiment against the legislation.

This situation places transgender-inclusive health insurance benefits at tremendous risk at a time when such benefits have just begun to appear with some regularity on the corporate and public benefits landscape. Increased penetrance of transgender-inclusive health insurance over the next few years will be critical for combating challenges from conservative politicians that such benefits are deviant, unnecessary, and a prohibitively expensive waste of taxpayer dollars. Failure to act in a timely manner to demonstrate that SRT benefits are already a part of standard health insurance, medically necessary, and affordable may result in legislative exclusion from UHI in the same manner that transgender people were excluded from the Americans With Disabilities Act in 1990.

At this political juncture, the transgender community must demand elimination of exclusionary language from existing health insurance plans in order to prevent broader and more far-reaching exclusions of care. Individual advocacy within corporate America is increasing the number of employers who offer SRT-inclusive health care for their transgender employees. However, broader action from every civil rights organization that serves the transgender community is essential to avert the coming crisis. Transgender as well as LGBT advocacy organizations must first follow the lead of organizations such as the HRC and the National Center for Lesbian Rights, which provide health care benefits inclusive of SRT to their own employees (Buchanan, 2007). In addition, organizations, such as the HRC, that are able to broadly influence the behavior of corporate America have the unique capability and responsibility to create timely change to help avert exclusion of SRT from any UHI program. Acceptance of a policy of incremental change will perpetuate the profound vulnerability of the transgender community to permanent exclusion and marginalization within the U.S. health care system.

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